DAKOTA EYE CARE ASSOCIATES

FINANCIAL POLICY

Dakota Eye Care Associates is pleased that you have selected our practice to provide eye care for you and your family. To serve you better and avoid confusion, please read our financial policies below.

INSURANCE CLAIMS PROCESSING: Dakota Eye Care Associates will process any/all insurance claims, for which we are contracted providers, on behalf of our patients. Since it is impossible for us to keep track of every insurance plan and how it works, we expect you to know your coverage, co-pay and deductibles. Dakota Eye Care Associates will assist you with your insurance coverage and paperwork to the best of our ability if you present your current insurance card or information at the time of service.

IF YOU HAVE NO INSURANCE: If you do not have insurance that covers your exam services, payment is expected at the time of service.

CO-PAY/CO-INSURANCE: All co-pays and co-insurance required by your insurance company will be collected at the time of service. If the co-pay or co-insurance is not known at the time of service you will be billed for these fees.

REFERRALS/ PRE-CERTIFICATION/PRE-AUTHORIZATION: If an insurance referral, pre-certification or pre-authorization from another provider is required, you must present it at the time of service. If you choose to be seen without the proper referral, you agree to be responsible for all charges should they not be covered by your insurance company.

MEDICARE PATIENTS: I understand that the refraction portion of my examination is not a covered service by Medicare and, therefore, it is my responsibility to pay for this portion of the examination. A Medicare supplemental policy may pay for this service. Please refer to the Medicare ABN Form.

DISPUTES: If for any reason you dispute coverage or payments made by your insurance company, it is your responsibility to contact your insurance company and to resolve the matter based on your insurance companies arbitration or resolution process. We will provide documentation to assist you in dispute resolution.

I understand and agree that regardless of my insurance, I am ultimately responsible for the balance of my account for any services rendered. I acknowledge that I have read and understand the foregoing.

Patient Signature_____ Date_____

Guardian or family member if patient unable to sign_____

DAKOTA EYE CARE ASSOCIATES

Date:_____

REQUIRED SIGNATURE FORM – All agreements are in effect until I chose to cancel them.

Name of Patient:_____DOB:_____

Name of Insured:_____ DOB: _____

_____ **Initials: RECORD RELEASE:** I agree that my medical and/or billing information may be given to or sent to Dakota Eye Care Associates, my referring doctor, referral doctors, insurance companies and/or treatment facilities.

_____ **Initials: ASSIGNMENT OF BENEFITS:** I request that payment of authorized benefits for myself and/or my dependents be paid directly to Dakota Eye Care Associates for services rendered. I agree that my medical information may be released to my insurance company as needed for payment and health care operations. I agree that a copy of my authorization may be used in place of the original.

_____ **Initials: RELEASE OF INFORMATION BY PAYORS AND NETWORKS:** I authorize Medicare, my insurance company or health organization, other payers, payer network organizations, including accountable care organizations, and their contractors, and third party administrators to share my health records and information obtained from my health care provider or any other provider, with my health care provider as needed for payment and health care operations.

_____ **Initials: HIPAA – NOTICE OF PRIVACY PRACTICES (NPP):** I acknowledge that I have reviewed Dakota Eye Care Associates HIPAA policy and I understand the full HIPAA policy is available for review at the front desk and on Dakota Eye Care Associates website. I have read and understand that my protected health information may be used for normal health care business for scheduling appointments, planning my treatment and obtaining payment from insurance companies.

_____**Initials: HIPAA – EMAIL, TEXT AND MOBILE PHONE COMMUNICATION:** Knowing that standard email, text and mobile phone communication may not be totally secure, I still consent to communications from my doctor and staff through my standard email, texting and mobile phone devices.

_____ **Initials: CONSENT TO TREATMENT:** I request Dakota Eye Care Associates to plan and provide treatment to me and/or my dependents with my participation. I understand that I may withdraw this consent and terminate treatment at any time and for any reason.

OPTIONAL: I authorize the release of my personal health information to the person(s) named below:

_____	_____	_____	_____
Name	Relationship	Name	Relationship

Patient Signature:_____ Date:_____

Guardian or family member if patient unable to sign:_____